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THE
Hampden Hippocrat
JANUARY—FEBRUARY 1994

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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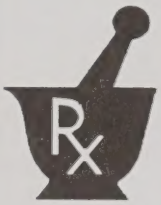

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From the Editors

The New Year is upon us, and CHANGE continues to afflict society, especially medicine, from all sides. There is a widespread feeling of uncertainty in the air. Our profession suddenly realizes that its advocates are relatively impotent when compared with the other interest groups besieging our lawmakers. We have less control over our futures than we would like, and those who do not control them don't understand much, it seems. But the juggernaut rolls on, and it will be fascinating to see how things look next year this time. ■

Brigid Glackin, M.D.
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Social Aspects of Primary Care

Over the past several years interest has been rising in primary care as a partial remedy for the ills of our health care system. The chorus for change has several components of varying validity—those concerned with public health issues, those concerned with access to the underserved and those concerned with their bottom lines. Indeed primary care touches on all those concerns.

Francis D. Horrigan, M.D., President

Public health issues are often concerned with the identification and management of factors causing or preventing disease. Primary care has a huge role here: participating in vaccination programs, prenatal care, smoking and substance abuse counseling and treatment, and risk factor modification are examples. The primary care physician can also advocate for public policy impacting health issues, e.g. gun control and seat belt legislation. Advocates for the underserved seek a good basic level of care for their clientele who are isolated by economic or cultural alientation in the inner city or, by geography in far flung rural areas. While the causes of the service deficiency may be different the effects are similar, that is, inadequate facilities and inability to support a physician (or even a physician extender). Finally, the last group also has a good idea although often, I suspect, for the wrong reason. While the primary care physician becomes a marketable, identified entrance to health care, this physician then becomes a filter to access to specialists and their expensive technology.

In addition to the public and preventive functions referred to above, the primary care physician provides people a point of access to the health system. The key word here is people with their family concerns, jobs, life styles and all the baggage that goes with being a person of the nineties. The primary care physician more than anyone in the "system" is in the best position to develop a comprehensive health plan consistent with both good medical practice and the patient's values. The physician can then appreciate and manage the effects of an injury or disease on the patient and, when necessary, select the treatment options which best suit the patient's needs. The primary care physician needs to know when (s)he doesn't know and to recognize the need for a higher-tech approach, at that point making the appropriate referral to the specialist. The primary role does not end here and may become even more crucial as (s)he becomes the liaison, reviewing for the patient and family what they either didn't hear or didn't understand regarding the problem as well as monitoring the other (non special) aspects of the patient's care. This is patient centered rather than disease centered care.

Given the obvious pivotal role of the primary care physician, why are their relative numbers shrinking from 50% of physicians 30 years ago to 30% of physicians now? The usual reasons cited are the fascination with specialized

technology, the greater social and economic status of specialists and an esteem problem among primary care types. The proposed solutions for this situation include a variety of coercive and regulatory policies which might create more problems than they solve. Examples are loan forgiveness programs if you "serve time" in an underserved area or forcibly rachetting residency programs to stamp out X number of Y kind of doctors, (reminiscent of other affirmative action programs) or have non physicians do it (how's that for your esteem?).

Reflecting back on my medical school and post graduate training in internal medicine we studied many cases of tertiary interest and attended many grand rounds studying the rare and the esoteric. All too often we learned of how the center identified the rarest of maladies saving the patient from the benighted but well meaning ministrations of the PMD (private medical doctor). Fortunately there was the community hospital rotation where understanding attendings guided us through patient care. I would recommend that medical educators use these practicing attendings as teaching role-models for primary care, that there be more grand rounds on the efficient management of "routine" outpatient problems and that continuing medical education be geared to the shifting focus from inpatient to outpatient medical care.

We need to resist mightily all attempts at divisiveness between primary and specialty practice. We must recognize the marvelous strides and opportunities that specialty research and technology have brought. Much of today's primary care was yesterday's specialty. We cannot stifle scientific advance by pre-programming our young physicians. The ideal and proper management of our patients involves at all times the close cooperation and mutual respect between generalist and specialist.

The role of the generalist brings to bear all the scientific, diagnostic and therapeutic skills we learned in school and training, and makes primary care itself a specialty. ■

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Health Care Reform And The Future Of Medicine

Don Higby wrote the following late at night after reading too many special articles and editorials in the New England Journal of Medicine.

It is highly likely that a health care reform package will be forthcoming in the next year or so. It is even more likely that this will contain elements which will greatly change the way medicine is practiced. We are all aware of the Clinton concept, which includes consortiums to sell comprehensive health care, consortiums to buy it, and regulatory agencies to keep the costs and services in line. Several codicils are evolving. There will be pressure on academic institutions to shift educational efforts towards primary care (whatever that is). There will be "malpractice reform" which is unfortunately emerging as a series of "suggestions" and alternative methods of resolving disputes, rather than eliminating the current tort system. In fact, to change the system in a positive direction is likely to require a constitutional amendment. There will be a "different way" of financing medical education and medical research, probably through a grants mechanism. Although fee-for-service practice will still exist in theory, the system is designed to greatly reduce this segment of the health care equation—to opt for a fee-for-service program will cost more. The effect on private biomedical research will be profound but indirect.

"The worst thing about the forthcoming system is that it is so irreversible."

We can expect that Congress will exempt itself from the system, since it would not do for our leaders to be involved in a health care program which was trying to reign in costs, deny marginally effective therapies, and ration. The AARP has already flexed its muscles, and it is not likely that Medicare will be folded into the plan. Federal civil servants and the military will continue to enjoy a system which rivals the best of private health care plans; and of course the inefficient and increasingly superfluous Veterans Administration system will continue to function. There is a real possibility that very large corporations which now "self-insure" will continue to be able to operate apart from the system, as will unions, with of course a decrease in autonomy.

Various alternatives to and critiques of the Clinton proposal have been advanced. The two extremes are a) to leave everything alone since it has not been arguably demonstrated that the current system doesn't work; and b) to develop a single-payer system with a defined list of services, critical paths to tell the provider what is and is not permitted, and costs set by some sort of administrative structure. The first extreme is not feasible, since it has no significant body of defenders at a policy-making level; and the last is simply not possible in this society at this time, given the fact that the policy-makers are still interested in re-election. The most likely outcome will be some watered-down version of the Clinton plan.

The new health care system will retain politically popular elements. These will include:

a) Universal coverage
b) Disincentives for fee for service, for "cadillac" plans, and for health care plans outside the system other than those sanctioned by the government.
c) A reduction in the number of physicians trained in this country, together with an increased emphasis on production of "primary care" physicians.
d) No real reform in the malpractice situation (Lawyers, after all, are puting the plan together!)
e) Direction of medical research by social

engineering rather than via the marketplace

f) Developing critical paths which tell providers what can and cannot be done in various disease states.

The new health care program will have certain predictable consequences; but consider the above and their consequences.

1. Universal coverage will increase demand. This is not necessarily a bad thing. Nevertheless, the ill and worried well who currently avoid the system will have less disincentive.
2. The disincentives for fee for service and "cadillac" programs will tax ingenuity, but there will be the development of a health underground (as there already is in AIDS and cancer) as well as an increase in offshore programs catering to American citizens. These of course will be unregulated.

3) The emphasis on turning out increased numbers of primary care physicians and fewer specialists will make medicine increasingly resemble a skilled trade. With fewer specialists, there will be much less incentive for specialists to innovate and develop new treatments—they will have all they can do to exercise their specialties. Since the body of information is already there, the generalist population will not be homogenous; in smaller communities, when the alternative is to send a patient to another city to see a specialist, generalists will develop "specialty" roles, as they have already in isolated cities and towns in the west, where Dr. X is considered the local expert in hearts and Dr. Y is pretty good with asthma. One overall effect will be to reduce the level of expertise which is acceptable. (This is not to denigrate generalists; the current system promotes professionalism among all practitioners). Another consequence of the emphasis on generalism will be arguments over what a generalist is. Currently Family Practice, Internal Medicine, Pediatrics, and Obstetrics/Gynecology claim the title. But how about Adolescent Medicine? Sports Medicine? Gerontology? What about the vast number of practitioners who have specialty training but also practice general medicine? What about specialties like Medical Oncology, Nephrology, Pulmonology, Cardiology, etc, where patients with a primary diagnosis in the specialty are by default cared for by a specialist in that field, since caring for incidental illnesses requires taking into account the nuances of the primary diagnosis? There may be 37 million uninsured people in this country which may roughly equal the number of people without primary care

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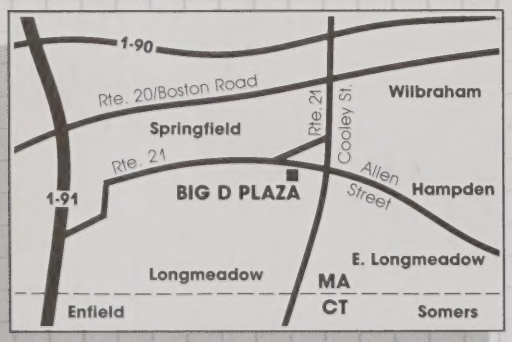

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Health Care Reform

Continued from previous page

physicians, but it is likely that there are a similar number of patients who are receiving all their medical care from specialists even if they have a primary care physician on paper.

4) Since malpractice reform will perforce be voluntary until constitutional change takes place, the forthcoming environment will increase rather than decrease litigation. Consider the current situation where suits are being prosecuted all over the country over the issue of denial of benefits for high dose therapy with stem cell support for breast cancer; or denial of benefits for the use of IL-2 in malignant melanoma. In most cases, these suits are against HMO style providers.
5) Had health care planners been responsible for designating research goals, they would have undoubtedly not supported the development of GNRH analogues for the treatment of prostate cancer. After all, the only advantage of these agents is that the patient will not have to undergo a surgical orchiectomy. Similarly, breast conservation treatments turn out to be more expensive in the long run than mastectomies. Is there a good reason to have a drug like finasteride around when it doesn't work all the time, is expensive, and takes a while to work—when a TURP can be done safely and quickly? The list could be expanded by several pages at least. If there are only 10,000 new patients with hairy cell leukemia in this country an-

nually, and if half don't need treatment and half the others can be treated with splenectomy, is it societally cost-effective to develop drugs to treat these patients? Research is currently driven by intellectual curiosity, by desire for academic advancement, by compassion, and by the possibility of profit or an increase in knowledge (indirect profit) on the part of those providing the funds. What will research be like when it is driven by "the greatest good for the greatest number?"

6) As we develop critical paths so that we can tell exactly what is acceptable and what is not when one is caring for a victim of gall stones, Alzheimer's disease, or pancreatic cancer, we define what is acceptable (instead of, as present, defining what is not acceptable). This will result in a situation where it will take an "act of Congress" to change these critical paths. Furthermore, since critical paths will be subjected to the political arena, they will probably be irrational. The politization of Medicine is evident in HIV disease, where a growing body of law and regulation as well as research funding has created a separate set of rules (many irrational) for health care related to this entity. This will only increase as we shift the paradigm to defining what is permissible in caring for patients.

There must be health care reform. There will be unintended and unwanted consequences of whatever proposal we eventually have. The worst thing about the forthcoming program is that it is so irreversible. ■

In Memoriam

Warren D. Platt, Jr., M.D., passed away on November 28, 1993. Dr. Platt graduated from Princeton and the College of Physicians and Surgeons at Columbia University. He served in the Navy during World War II. He practiced Internal Medicine with the Springfield Medical Group.

Lawrence H. Doolittle, M.D., expired on December 21, 1993. He graduated from Wesleyan University and Boston University School of Medicine. He began his career as a general practitioner, and later returned to Springfield after taking advanced training in Urology. He leaves a son, Jerome.

Walter S. Mozden, M.D., passed away on December 24, 1993. He graduated from the University of Massachusetts and Boston University School of Medicine. He served in World War II and the Public Health Service before beginning his practice in surgery and gynecology in this area. From 1974-1984 he was director of Utilization and Quality Assurance at Baystate Medical Center. He leaves his wife, Dorothy, two sons, and five daughters.

Joseph E. Slowick, M.D., expired on December 29, 1993. He graduated from Clark University and Tufts College of Medicine. He practiced Medicine and Surgery in the area. He leaves a son and two daughters. ■

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The Family Birthplace

The Greater Springfield community can be proud of still another advance in what is available to patients in the area. The following was contributed by Kevin Hamel and Karne Adamski.

Providence Hospital ushered in a new era in maternity care January 16th, when it unveiled its newly renovated Family Birthplace.

The Family Birthplace is the result of a 1.5 million dollar renovation project. The result is a spacious, "homey", ultra-modern facility that stresses family in every sense of that word.

"The rooms are designed with the comfort of the mother, child, and other family members in mind".

Each of the ten labor/delivery/recovery/postpartum rooms—designed to allow the mother to stay in one room for the entire birth experience—features its own bathroom and shower, a color television/VCR, telephone, crib, rocking chair, and comfortable sleeper/recliner.

"The rooms are designed with the comfort of the mother, child, birthing partner and other family members in mind," said Claire Margosiak, R.N., Nurse Manager, Family Birthplace. "The philosophy here is to provide a setting as close to home as possible, stressing both comfort and security.

"Delivery of a baby, particularly one's first baby, is a very important, very special time for a family," she said. "We want that experience to be as pleasurable as we can make it... the memories should be of excellent care and wonderful facilities. Those are the kinds of memories we create here."

While the look of the Family Birthplace is new, the standard of the care is the same that has made it the premier maternity facility in the Greater Holyoke area.

The Family Birthplace has 19 board-certified obstetrician-gynecologists on staff. In addition, eight certified nurse midwives are associated with the facility.

"The Family Birthplace takes a family-centered approach, from prenatal classes through newborn care," said Margosiak. "Throughout the birthing experience, nurses provide individualized care for both mother and baby."

Special help is available from professionals, including a lactation consultant, and a "Baby & Me" helpline is also offered to parents who have questions about their newborn's care after leaving the hospital.

In addition, all mothers delivering at the Family Birthplace will receive a follow-up visit by a registered nurse within 24 hours of discharge. This service, part of the Family Birthplace's Home Visit Program, provides additional healthcare support for mother and baby once they have returned home. The program serves all of Western Massachusetts. ■

Hampden Committee Activities

Our secretary brings us up to date on activities of the HDMS.

The Medico-Legal Committee held their Second Annual Forum on October 14, 1993 at Storrowton Tavern's Carriage House. Fifty physicians and lawyers attended the forum, titled "Medical-Legal Ramifications of the Health Care Proxy". Our speakers, George E. Karras, Jr., M.D. of Mercy Hospital's ICU/CCU and Attorney Theordore Brown of Egan, Flanagan and Cohen, both gave informative presentations in respects to the medical and legal professions. Members of both professions agreed it was an excellent program.

The Ninth Annual Medical Ethics Seminar, presented by the Medico-Religious Committee was held on October 20, 1993 at Mercy Hospital's Deliso Center. 107 health care professionals, social workers and clergy attended the forum titled, "Ethical Decisions-Continuation of Medical Care". This year we had two speakers, Dr. Michael Rosen, Medical Director of Hospice of Pioneer Valley, and Dr. Steven Reichert, who works out of Wing Memorial Hospital. Our panel consisted of Attorney Theodore Brown of Egan, Flanagan and Cohen, Reverend Gary DeLong of the First Church of Christ in Longmeadow, and Anne-Marie Ferraro, a pastoral care giver for the Hospice of Pioneer Valley. Everyone involved with the program did an excellent job and plans are underway for Forum #10.

The Meidico-Religious Committee met in November and December. Evaluations from the Ethics Forum held in October were reviewed and found to be very positive. A great number of evaluations suggested a seminar be held on "Assisted Suicide". The committee agreed and have decided that will be the topic for the 10th Annual Medical Ethics Seminar to be held on October 19, 1994. The committee felt that this being our 10th seminar, something special should be done. They decided to try to obtain Professor Arthur Dyck as their speaker, considering he was the speaker for the 1st seminar 10 years ago. Professor Dyck was contacted by Reverend Benander and has agreed to come and speak on October 19, 1994.

The Public Health Committee met in November and December. Dr. Riley, the Chairman, asked

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Hampden Committee Activities

Continued from previous page

for suggestions for new members to join the committee. A notice has also been printed in the December Newsletter. The committee is waiting to hear from Mrs. Sally Wittenberg of the Springfield School Volunteers in regards to how best we could participate in the Volunteer Program.

Dr. Deloris Williams, Public Health Commissioner for the City of Springfield, attended the meeting in December and reviewed department events of the past year. The Southwest Neighborhood Health Center received a grant in the amount of $358,406.00 for nine months. $230,000.00 has been obtained from the state Office of Non-Smoking to work on establishing an ordinance which would ban the sale of cigarettes to minors and also an ordinance which would ban smoking in all restaurants. The ordinance has been passed by the Public Health Council and is now waiting for the approval of the Springfield City Council.

A Community Health Network has been established statewide. Springfield is participating in CHNA #4 with thirteen other towns. Their first project would be to try and reduce the number of STD cases by area. The age groups between 14 and 19 will be targeted with the goal being to reduce the STD rate by 10% before June 1994. Other projects being worked on are an April Infant Mortality Walk, a Needle Exchange Program a Parish/Nurse program, smoking cessation education for pregnant women, etc.

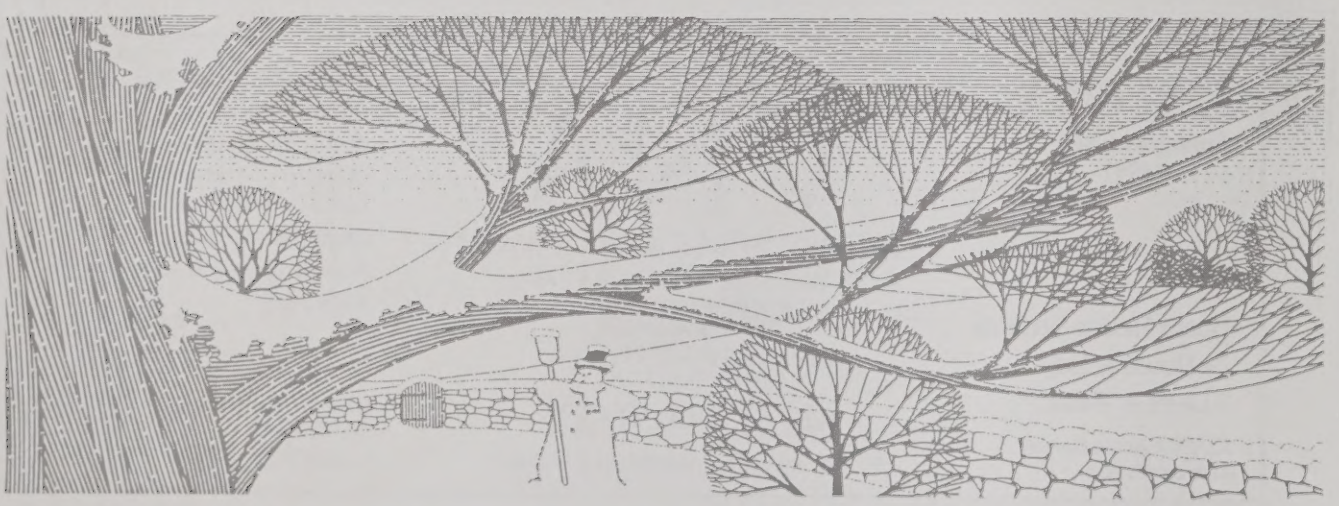
The Executive Committee met in November and December. Dr. Horrigan has asked members of the Executive Committee to volunteer to serve on an Ad-Hoc Committee to work on establishing a Public Service Recognition Award.

The Scholarship Committee, co-chaired by Drs. Coen & Bloom, reported that nine medical students received awards this year. Six students were awarded scholarships of $900 each. Two students received scholarship loans of $900 each and one student was granted a $500 scholarship loan.

Ms. Barnes reported on the two grants she has submitted to help fund the Poster Contest and House Calls Program this year. The first grant deals with preventing 3rd grade students from 2 counties from starting to smoke. This grant would fund Poster Contest #4. The second grant is aimed at reducing and preventing smoking among hard to reach groups in Hampden County. This grant would fund the House Calls Program. A reply is hoped for towards the end of December.

Our Winter District Meeting will be held on January 25, 1994 at the Sheraton Springfield Monarch Place. Our speaker will be Dr. Robert McAfee, President-Elect of the AMA. The entire New England Delegation to the AMA has been invited.

Since we traditionally have the AMA Presdent-Elect speak at the January meeting, it was suggested that we invite our resident members to attend. Motion was made, seconded and passed to invite residents annually to be our special guests at the January District Meeting. ■



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AMA to Congress: Doctors must make medical decisions in a reformed system

Physicians are "deeply concerned" the Clinton administration and others proposing health system reform would turn medical decision-making over to insurance companies and government bureaucrats.

In a Nov. 5 speech to the Commonwealth Club of California, AMA EVP James S. Todd, MD, expressed this concern, adding that reform will not succeed if doctors go from being patient advocates to simple allocators of services.

The speech, scheduled for broadcast through National Public Radio on 150 stations in 37 states, was the Association's first public address since President Clinton submitted his health system reform bill to Congress Oct. 27.

Applauding the Clintons for setting the stage for system reform, Dr. Todd turned comments toward Capitol Hill, saying the AMA will work hard to convince Congress to approve a bill that does not compromise patient care or the trust of the physician-patient relationship.

"It's time to set the rhetoric aside and start looking at what we have to work with, and decide exactly what it is we must have and what we don't need," Dr. Todd said. "The medical profession has definite views on how we think this process should unfold."

As the reform process turns to negotiations and compromise, Dr. Todd warned Congress that any plan calling for price controls, new layers of bureaucracy and overregulation will limit resources for patient care.

"Limits may be placed on the market forces that drive the kinds of vibrant competition we will need to sustain reform over a long period of time," he said.

Financing reform remains unclear, Dr. Todd said, adding any plan that relies heavily on Medicare and Medicaid cuts will threaten medical services for the poor and elderly "without providing the big bucks required to pay the bill."

He cited "the country's top economists," who warn that if anticipated savings fail to materialize," it will trigger deep reductions in medical services and destroy the promise of reform."

To find a "common ground" on reform, Dr. Todd said "it is essential that the discussion be constructive and nonpartisan and that all players work together to move the country toward consensus."

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

Detective Stories

Have you got a case that makes a good "detective story"? If so, please write it up and send it in.

1. A 38 year old man was referred because of unexplained edema of the left arm. He was asymptomatic otherwise, and noted no pain or disability. His past history was significant in that he had had stage II nodular sclerosing Hodgkin's disease 12 years before, and had received a mantle field of radiation.

To complicate matters, the patient had a vascular occlusion involving the right arm and remedied by resection of the first rib to relieve a thoracic outlet syndrome. However, he had a thorough evaluation of the left vascular system and there was no evidence of vascular occlusion.

"What explains the findings?"

The chest x-ray demonstrated some long-standing left upper lobe fibrosis which had been unchanged for at least five years.

The physical examination in addition to showing an edematous left arm, with good venous drainage and good arterial pulses, and no neurologic abnormalities, disclosed a 5 centimeter oval patch on the upper left chest with depigmentation, depillation, and neovascularization.

Why did the patient have a swollen left arm?

2. A 70 year old woman presented with a chief complaint of large black hairs growing on her face together with oily and bad-smelling skin. She had been told by several physicians that, since there were so few hairs, she should trim them and wash her face more frequently.

As a teenager the patient received facial irradiation for acne; in her 30's she developed multiple basal cell carcinomas. Ultimately, she underwent bilateral full thickness skin grafts to replace most of the involved skin. These were rotated from the axillary areas.

The physical examination did indeed disclose a small number of long thick black hairs growing from both cheeks. In the process of the diagnostic studies which followed, it was noted that the patient had an hemoglobin of 15 Gm%. Other blood studies were normal, she was not a smoker, and she had normal pulmonary function tests and normal blood gases. Chest x-ray and IVP were normal (this was before they had CT scans).

What explains the findings?

Solutions:

1. The clue was the skin lesion and the left upper lobe fibrosis. The skin lesion was typical of those left by kilovoltage radiation. The records were taken out of storage and reviewed. It turned out that the patient had received not only a standard mantle field (4400 rads) but had received a "boost" to deal with a large node mass in the left axillary area. Calculations showed that some areas had received up to 8000 rads. This is a sufficient dose to result in late fibrosis or even sarcoma.

2. The elevated hemoglobin was obviously not due to pulmonary dysfunction, nor a renal cancer. Polycythemia vera was entertained, but further studies were inconsistent. Finally, a serum testosterone was drawn, and this was in excess of 4000 mg%. Selective cannulation of ovatian veins ultimately disclosed an arrhenoblastoma, which was resected. The "cosmetic" problems were related to the fact that axillary skin had been transplanted to the face. ■

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Sonnet On Sitting In On Another Stupid Meeting

How did I end up so far from the door?
Perhaps I'm not as smart as people think.
The topic (which I've heard) drives me to drink.
The overheads are, sadly, quite a bore.

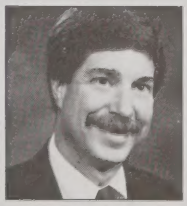
Through meeting after meeting I have sat,
Because I want to be responsible.
But now, my eyelids heavy, bladder full,
To be elsewhere! I want nothing but that.

Oh, God to leave—give me an excuse!
Set off my beeper; spare me this abuse. ■

John Keats, Junior

ARE YOU CONCERNED ABOUT

- the impact of the medicare-medicaid anti-kickback regulations on your daily practice?
- the tax treatment of employees versus independent contractors?
- structuring employment, partnership and shareholder agreements for group practices?
- malpractice claims due to inadequate informed consent?
- reducing estate taxes, and protecting assets from creditors' claims?
- providing for the orderly disposition of your practice in the event of death or disability?



Attorney
Arthur W. Price

Arthur W. Price and Michele J. Feinstein, partners in Cohen, Rosenthal, Price, Mirkin & Wernick, have more than twenty-five years of combined experience in representing area physicians in their practices and individually. They counsel solo and group practices in their day to day businesses as well as in their planning for growth or extraordinary concerns. They also advise physicians on personal and family problems.

Call Arthur W. Price or Michele J. Feinstein to discuss your practice or personal concerns. We're here to help.

Attorney
Michele J. Feinstein

COHEN, ROSENTHAL, PRICE, MIRKIN & WERNICK, P.C.

ATTORNEYS AT LAW

One Monarch Place, Suite 1300, Springfield, MA 01144-0001
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New Members Welcome

Jane R. Cross, M.D.
Holyoke Health Center
30 Center Street
Holyoke, MA 01040

Born: February 18, 193
Premed: Hampshire College, Amherst, MA 1972-1974
Brown University, Rhode Island 1976-1978
Medical: Yale University School of Medicine 1978-1982
Internship: St. Christopher's Hospital for Children, PA 1982-1983
Residency: Yale-New Haven Hospital, CT 1983-1985
Specialty: Pediatrics

David M. Drvaric, M.D.
Shriner's Hospital
516 Carew Street
Springfield, MA 01104

Born: October 28, 1952
Premed: Harvard University 1970-1974
Medical: Emory University, Georgia 1974-1978
Internship: Duke University Medical Center 1978-1979
Residency: Duke University Medical Center 1978-1979
Fellowship: Children's Hospital, Louisiana 1984-1985
Specialty: Orthopedic Surgery

Daniel R. Grow, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 14, 1962
Premed: Lehigh University, PA 1979-1983
Medical: Pennsylvania State University 1983-1987
Internship: York Hospital, PA 1987-1988
Residency: York Hospital, PA 1988-1991
Fellowship: Eastern Virginia Medical School 1991-1993 Reproductive Endocrinology
Specialty: Obstetrics/Gynecology/Reproductive Endocrinology

Stephen Machinton, M.D.
8 Isabelle Street
Holyoke, MA 01040

Born: November 6, 1945
Premed: University of Pennsylvania 1963-1967
Medical: Hahnemann Medical College, PA 1967-1971
Internship: Lankenau Hospital, PA 1971-1972
Residency: Albert Einstein Medical Center, PA 1972-1975
Specialty: Obstetrics/Gynecology

Judy R. Mangion, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 26, 1963
Premed: Vassar College, NY 1982-1985
Medical: The George Washington University 1986-1990
Internship: George Washington University Medical Center 1990-1991
Residency: George Washington University Medical Center 1991-1993
Fellowship: Baystate Medical Center 1993-Present Cardiovascular Disease
Specialty: Cardiovascular Disease
Fellow

Bruce L. Seaton, D.O.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 4, 1961
Premed: SUNY at Stonybrook 1979-1981
Brandeis University 1981-1983
Medical: New York College of Osteopathic Medicine 1985-1989
Internship: Brookdale Hospital Medical Center, NY 1989-1990
Residency: New York University Medical Center, NY 1990-1993
Specialty: Anesthesiology

Continued on next page

New Members Welcome

Continued from previous page

John E. Murphy, D.O.
200 North Main Street #1201
East Longmeadow, MA 01028

Born: March 18, 1953
Premed: University of Massachusetts 1985
Medical: University of New England College of Osteopathic Medicine 1985-1989
Internship: UMass Medical Center 1989-1990
Residency: UMass Medical Center 1990-1992
Specialty: Family Practice

Charles M. Simmons, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01189

Born: June 22, 1956
Premed: Pacific Union College 1976-1980
Medical: Loma Linda University School of Medicine 1981-1985
Internship: Loma Linda University 1985-1986 Surgery
Residency: Loma Linda University 1989-1992 Emergency Medicine
Specialty: Emergency Medicine

Gabriel M. Cohn, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 14, 1958
Premed: Brooklyn College, New York 1976-1980
Medical: State University of New York, Syracuse 1982-1986
Internship: State University of New York Syracuse-Health Science Center 1986-1987
Residency: State University of New York, Syracuse-Health Science Center 1987-1990
Fellowship: National Institutes of Health, Maryland 1990-1992
Specialty: Obstetrics/Gynecology/Clinical Genetics

Paula A. DeYoung, M.D.
444 Montgomery Street
Chicopee, MA 01020

Born: August 21, 1963
Premed: Wellesley College, MA 1981-1985
Medical: Boston University School of Medicine 1985-1989
Internship: Women & Infants/Brown University 1989-1990
Residency: Women & Infants/Brown University 1990-1993
Specialty: Obstetrics/Gynecology

Nancy M. Kloczko, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 2, 1951
Premed: College of New Rochelle, NY 1969-1973
Medical: University of Connecticut School of Medicine 1975-1979
Internship: University of Connecticut Combined Pediatric Residency Farmington/Hartford/Newington 1979-1980
Residency: University of Connecticut Combined Pediatric Residency Farmington/Hartford/Newington 1980-1982
Fellowship: Children's Hospital, Boston 1984-1986
Specialty: Pediatrics/Behavior Development

David L. Maguire, M.D.
2 Main Street
Monson, MA 01057

Born: December 11, 1947
Premed: Georgetown University 1966-1970
Medical: Georgetown University Medical School 1974-1978
Internship: University of Massachusetts Medical Center 1978-1979
Residency: University of Massachusetts Medical Center 1979-1981
Specialty: Internal Medicine

Terrence W. Norchi, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 28, 1964
Premed: Kent State University, Ohio 1983-1986
Medical: Northeastern Ohio Universities College of Medicine 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-1993 Chief Resident 1993-Present
Specialty: Internal Medicine
Resident

Jeannine K. Ritchie, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 28, 1967
Premed: John Hopkins University, Maryland 1985-1989
Medical: University of Vermont Medical School 1989-1993
Internship: Baystate Medical Center 1993-1994
Specialty: Internal Medicine
Resident:

Stanley J. Swierzewski III, M.D.
1221 Main Street
Holyoke, MA 01040

Born: September 27, 1958
Premed: University of Massachusetts 1983
Medical: Tufts University School of Medicine 1984-1988
Internship: University of Michigan Medical Center 1988-1990
Residency: University of Michigan Medical Center 1990-1993
Specialty: Urology

Alan Y. Tso, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born:
Premed: The City College of New York 1979-1986
Medical: State University of New York, Syracuse 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-Present
Specialty: Internal Medicine/Pediatrics
Resident:

Martin A. Worrall, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: September 28, 1966
Premed: Williams College, MA 1984-1988
Medical: University of Connecticut School of Medicine 1989-1993
Internship: Baystate Medical Center 1993-Present
Specialty: Internal Medicine
Resident:

Hampden Hippocrat Deadlines For The Year 1993-1994

Please save the following:

ISSUE DATE	DEADLINE DATE
November/December 1993	October 15, 1993
January/February 1994	December 15, 1993
March/April 1994	February 15, 1994
May/June 1994	April 15, 1994
July/August 1994	June 15, 1994
September/October 1994	August 15, 1994
November/December 1994	October 14, 1994

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